CONSUMER NOTEBOOK SETUP

Agencies will want to maintain 2 formal notebooks: an MAR and the regular consumer file.
CONSUMER FILE: LIST ANY MEDICATION ALLERGIES IN A CONSPICUOUS PLACE SUCH AS IN RED ON OUTSIDE OF FILE.

A. EMERGENCY INFORMATION

1. Photograph/Data Sheet
2. Emergency Contact Form
3. Medicaid Information (usually maintained in small zipper bag)

B. ADMISSION INFORMATION

1. Review of Client Rights
2. Referral and Consent for Admission
3. Guardianship papers and information

C. PERSONAL PLAN INFORMATION

1. Copy of personal plan
2. A signed copy of the Personal Plan services and funding page (completed at initial/annual plan or when modifying a plan)
    a. Copies of any changes/modifications to plan via services and funding pages
3. Copies of monthlies should either go on top of the personal plan, or have a separate tab for them
    a. Ensure that the SC and the Provider monthlies are signed by both parties

D. PROGRESS NOTES

1. Running data sheets to be completed at least daily
2. After one month most providers file these in a separate file

E. MEDICAL INFORMATION

1. Doctor Orders Tab: This section should contain the latest order, no matter what Dr. has ordered it. Once new Orders are obtained and the physician has signed that they are current (usually quarterly), most providers file previous orders under the appropriate tab for that Dr.
    a. Orders should never be on a lab sheet or any other document
    b. Orders should contain PRN medication and any adaptive equipment

2. Consultation Report and Request Tab
3. Lab Results Tab

Most Providers like Tabs such as the following:

4. General Medical Tab, which would include the TB (Monitoux)Test (if not on the annual physical, Hepatitis Series documentation, mammograms, well woman exams, immunizations, etc. Or the provider may choose to have these sectioned under individual Tabs.

7. Specialists; such as neurologist, psychiatrist, etc., or the agency may want to break this Tab down per Dr., depending on how many specialists the person sees.

8. Monitoring/Treatments Tab: this tab could include weights, seizure reports, special monitoring needs, therapy reports, etc.

F. MEDICATION ADMINISTRATION Notebook:

1. **Previous** Medication Administration sheets

G. SPECIALIZED MEDICAL VISITS

1. Annual Physical
2. Dental exam
3. Eye exam

H. ASSESSMENTS

1. Behavioral assessments
2. School assessments
3. Judevine assessments

I. CORRESPONDENCE

1. Letters from/to guardians
2. Letters from/to school or day program
    a. Any other correspondence the agency has identified to keep.

K. BUDGET

SEPARATE NOTEBOOK

J. MEDICATION ADMINISTRATION Notebook:

2. Current Medication Administration sheets
3. Side effect sheets for current medications
    a. Some providers also choose to make a copy of the current Physician orders for this notebook as well.